

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06647

CERTIFICATE OF DEATH

Reg. Dist. No. 202

94a

1. PLACE OF DEATH:

Kent

County

Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

King's Grant Manor

How long in hospital or institution?

3. (a) FULL NAME

Laurence R. Blackhurst

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

B. (b) Name of husband or wife Wilhemina Blackhurst

7. Living 6. (c) If alive, give age years
7. Birth date of deceased (mo. day, yr.) Dec. 6, 18858. AGE: Years Months Days If less than one day
61 I 25 hrs. min.9. Birthplace Phila. Penna.
(Town, county, and state)

10. Usual occupation Executive

11. Industry or business DuPont Co. (Wilmington)

12. Name Charles John Blackhurst

13. Birthplace England

14. Maiden name Ida Stevenson

15. Birthplace Phila. Penna.

16. Informant L.R. Blackhurst, Jr.

Address Chestertown, Md.

17. Cremation Date thereof Feb. 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Silverbrook Crematory

Location Wilmington, Delaware

18. Funeral director J. Willis Wells

Address Chestertown, Maryland

19. Feb. 3, 1947
(Date rec'd by registrar)

Clara S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent

City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.E.D.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1947 19 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21, 1946 to Jan. 31, 1947 and that I last saw him alive on Jan. 31, 1947.

Immediate cause of death Coronary Thombosis DURATION Immediate

Due to Aterio Sclerosis Several Yrs.

Pariarteritis Nodosa

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

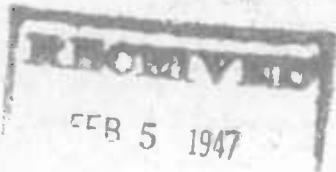
Means of injury Injured at work?

23. SIGNATURE

Frank Hines M.D.

M. D. or other

Address Date signed



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00648

Reg. Dist. No.

2030

CERTIFICATE OF DEATH

93d

1. PLACE OF DEATH:

County.....

Kent

City or town..... Park Hall

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?..... all time

Hospital, Institution, or street address where death occurred:..... Near Eastern Neck Island.

Now long in hospital or institution?.....

3. (a) FULL NAME

Raymond C. Carr

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

Married

6.(b) Name of husband or wife..... Margaret C. Carr

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... 55 years

July 28 1890

8. AGE:

Years

Months

Days

13 less than one day

56

5

14

hrs.

min.

9. Birthplace.....

Seaford Delaware

(Town, county, and state)

10. Usual occupation.....

Wateman

11. Industry or business

12. Name.....

Edward W Carr

13. Birthplace.....

Somyna Delaware

14. Maiden name.....

Mary L Colman

15. Birthplace.....

Kent Co. Maryland

16. Informant.....

Who Margaret C. Carr

Address

Rush Hall, Maryland.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 1/14/47

(month) (day) (year)

Cemetery or crematory.....

Wesley Chapel

Location.....

Rush Hall Maryland

18. Funeral director.....

Mauris V. William

Address

Chesapeake, Maryland.

1114

19. 47

S. E. Glazebrook, Registrar

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Rush Hall T. 18# 2

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Near Eastern Neck Island

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War # 1

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 12 1947 at 8:53 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-15 1947 to 1/12/47 1947

and that I last saw h..... alive on 1947

Immediate cause of death.....

Cardiac failure

Congestive heart failure -

Due to.....

Myocarditis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

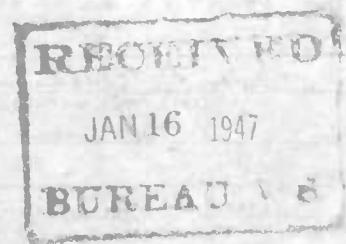
Means of injury

Injured at work?

23. SIGNATURE..... R. But W. Carr

M. D. or other

Address..... Chestertown, Md. Date signed 1-13-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

138

CERTIFICATE OF DEATH

00642
203

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Kent

City or town..... Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 16 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Charles Bernard Davis

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Ruth Ayres Davis

7. Birth date of deceased (mo., day, yr.)..... 9 - 9 - 1890 6. (c) If alive, give age..... 54 years

8. AGE: Years..... 56 Months..... 3 Days..... 29 If less than one day..... hrs. min.

9. Birthplace..... Rock Hall, Kent Co., Md. (Town, county, and state)

10. Usual occupation..... Waterman

11. Industry or business

12. Name..... George Davis

13. Birthplace..... Kent County, Md.

14. Maiden name..... Rose Harrison

15. Birthplace..... Kent County, Md.

16. Informant..... Charles Davis Sonken-Daughter

Address..... Rock Hall, Maryland

17. Burial..... Cemetery Chapel Date thereof..... 1 - 10 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cemetery Chapel

Location..... Rock Hall rural

18. Funeral director..... J. Willis Wells

Address..... Chestertown Md

19. 1/8 (Date rec'd by registrar)

19 47

S Elwood Burgess
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... Rock Hall or
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

215-20-0064

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 7 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12 - 26 1946 to 1 - 7 1947

and that I last saw h. m. alive on 1 - 7 1947

Immediate cause of death.....

Pulmonary hemorrhage

Due to.....

Pulmonary tuberculosis

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

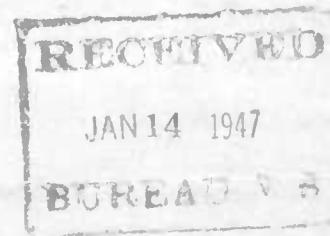
Means of injury Injured at work?

23. SIGNATURE..... Albert A. Burgess
M. D. & other

Address..... Rock Hall, Md. Date signed 1/7/47

~~60~~ 60
~~15~~ 360:
~~400~~ 15
~~475~~ 435

~~H. H. Kelly~~
Huey crack
Look-and $\gamma^{\prime 2}$
R. Green



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00650

CERTIFICATE OF DEATH

Reg. Dist. No.

2020

1. PLACE OF DEATH:

County

City or town

1 Kern
Alabama, Clarendon

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

14 years

Hospital, institution, or street address where death occurred:

Alabama
14 years

How long in hospital or institution?

3. (a) FULL NAME

John W. Dent

4. Sex

Male

5. Color or race

C

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1/7/85

6.(c) If alive, give age years

8. AGE:

Years
62Months
0Days
8it less than one day
hrs. min.

9. Birthplace

(Town, county, and state)

Va.

10. Usual occupation

Inmate of Alabama

11. Industry or business

FATHER

12. Name

JOHN F DENT

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

ANNIE GRAY

15. Birthplace

MARYLAND

16. Informant

SADIE DENT JONES

Address

NEW YORK CITY

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 15/41

(month) (day) (year)

Cemetery or crematory

Col. Cemetery OTHER NECK

Location

NEAR - County Home, Clarendon

18. Funeral director

Staff. Beyond Better

Address

Clarendon Ma

19. Date rec'd by registrar

Jan. 14 1947

Class S Barnes.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Ma

County

1 Kern

City or town

Clarendon

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 13

1947

at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1 1947 to

Jan. 13 1947

and that I last saw him alive on Jan. 11 1947

Immediate cause of death

Mental disease

DURATION

6 months

Due to Ch. Industrial Influenza

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hundt son

M. D. or other

Address

Wilmington, Del. Date signed Jan 13/47

RECEIVED

JAN 16 1947

1-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

00651

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 yrs.

Hospital, institution, or street address where death occurred:.....

304 Cannon St.
Kent & Queen King Hospital

How long in hospital or institution?.....

1 week

3. (a) FULL NAME

Simon Evans

4. Sex

M.

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Widowed

B. (b) Name of husband or wife.....

(late) Alice Evans

7. Birth date of deceased (mo., day, yr.)

March 15 1861

B. (c) If alive, give age..... years

8. AGE:

Years
85Months
9Days
26If less than one day
hrs. min.

9. Birthplace.....

Caroline Co. Va.

(Town, county, and state)

10. Usual occupation.....

Butcher

11. Industry or business.....

Voshell Hotel - Chesapeake

MOTHER FATHER

Thurston Evans

12. Name.....

Thurston Evans

13. Birthplace /at Royal Va.

Port Royal Va.

14. Maiden name.....

Agnes Clark

15. Birthplace Port Royal Va.

Port Royal Va.

16. Informant.....

Supt. Chas. Johnson (hus.)

Address.....

Chesapeake Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... 1/13/47
(month) (day) (year)

Cemetery or crematory.....

Chesapeake

Location.....

Chesapeake Maryland

18. Funeral director.....

Maurice C. Williamson

Address.....

Chesapeake Maryland

19. Date rec'd by registrar.....

Jan. 13, 1947

(Date rec'd by registrar)

Alice S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Chesapeake

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

304

Cannon St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

January 10 1947 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-7 1947 to 1-10 1947
and that I last saw him alive on 19

Immediate cause of death.....

Inanition; senility

DURATION

2 weeks

Due to.....
Duo to Arteriosclerosis. Cerebral

Other conditions.....

This man had no relatives and
any close friends.
(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

Robert S. Barnes

M. D. or other

Address.....

Chesapeake, Md.

Date signed 1-13-47

RECEIVED

JAN 15 1947

BUREAU S.

1-35

Evidence for the change of
usual residence of mother is
shown on G 100 2/10/47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21020

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 30 1947 at 10 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that last saw deceased on Jan 30 1947.

Immediate cause of death

Septicemia followed by

Malnutrition

Due to

Pneumonia

Due to

Pneumonia

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

16. Informant

Address

17. (Burial, cremation, or removal Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Location

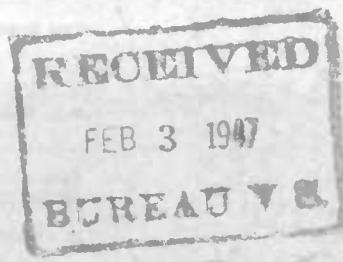
18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00653

CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1. PLACE OF DEATH:

County.....

Kent
Worton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Walter Fowler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

5. (b) Name of husband or wife

Mamie Spry Fowler

7. Birth date of deceased (mo. day, yr.)

Jan. 29, 1876

8. AGE:

Years Months Day If less than one day

70 II 9 hrs. min.

9. Birthplace

Kent Co. Maryland
(Town, county, and state)

10. Usual occupation

Pipe fitter

11. Industry or business

12. Name

John Fowler

13. Birthplace

Kent Co. Maryland

MOTHER

14. Maiden name

Emma D. DeFord

FATHER

15. Birthplace

Kent Co. Maryland

16. Informant

Mrs. Mamie Spry Fowler (wife)

Address

Worton Maryland

17. Burial

Date thereof Jan. 10, 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Chester Cemetery

Location

Chestertown, Md.

18. Funeral director

J. Willis Wells

Addressee

Chestertown, Maryland

19. Date rec'd by registrar

Jan. 9, 1947

(Date rec'd by registrar)

Clara S. Barnes

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent

City or town..... near Worton

(If outside city or town limits, write RURAL and give nearest town)

Street No..... R.F.D. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1947, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 15, 1946, to January 7, 1947

and that I last saw him alive on January 7, 1947

Immediate cause of death

Pulmonary T.B.

DURATION

1945

Due to

Due to

Other conditions

Tuberculosis

5 mo.

with Terminal Cancer

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

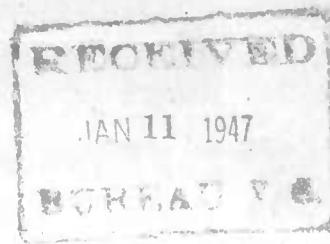
Injured at work?

23. SIGNATURE

M. D. or other

Address Chestertown, Md.

Date signed 8/47



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83d 00654

Reg. Dist. No. 203

1. PLACE OF DEATH

County Baltimore
 City or town Rock Hall Rural - PINEY NECK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Oliver Erskine Frazier Jr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male WhiteMarried

6. (b) Name of husband or wife

Mildred A. Frazier
living7. Birth date of deceased (mo., day, yr.) March 12, 1882

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

64 10 3

hrs. min.

9. Birthplace Rock Hall (rural) Kent Co Md
(Town, county, and state)10. Usual occupation Fatherman

11. Industry or business

Mildred FrazierDorchester Co Md.Charlotte AustinBaltimore Md.18. Informant Mrs. Mildred Frazier (wife)Address Piney Neck - Rock Hall, Md.17. Burial Date thereof Jan. 17, 1947
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Wesley Chapel Cem.Location Near - Rock Hall, Md.18. Funeral director J. Willis WellsAddress Chestertown, Maryland19. Date rec'd by registrar Jan 17. 1947 S. Edward Brown

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Rock Hall Rural, PINEY NECK
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 15, 1947 at 6 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1946 to Jan 14, 1947and that I last saw him alive on January 14, 1947

Immediate cause of death

Self Neglect DURATION 10 hoursDue to 3 other attacks of Neglect

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

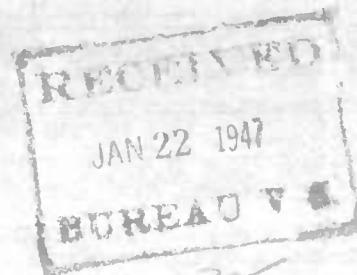
Means of injury

Injured at work?

23. SIGNATURE Frank W. Smith

M. D. or other

Address Electrical Corp. Md Date signed Jan 18, 1947



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00655

Reg. Dist. No. 202

97

1. PLACE OF DEATH:
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:.....
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Kent
 City or town..... Chesterstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 106 E Cannon St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Jonas Haughton
 4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced
 Single

6. (b) Name of husband or wife..... Mary A. Haughton
 Deceased

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1867
 6. (c) If alive, give age..... years

8. AGE: Years 79 Months 5 Days 12 It less than one day hrs. min.

9. Birthplace..... Edenton, North Carolina
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... Fertilizer Factory

12. Name..... Solomon J. Haughton

13. Birthplace..... North Carolina

14. Maiden name..... Unknown

15. Birthplace.....

16. Informant..... Arlington T. Haughton

Address..... 106 E Cannon St. - Chesterstown, Md.

17. Burial Date thereof..... Jan. 30 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Chesterstown Cemetery

Location..... Chesterstown, Md.

18. Funeral director..... M. V. Williams

Address..... Chesterstown, Md.

19. Date rec'd by registrar..... Jan. 30 1947

Date rec'd by registrar..... Class of Barnes

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Jan 27 1947 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 20 1947 to Jan 27 1947
 and that I last saw him alive on Jan 27 1947

Immediate cause of death.....

Due to..... Coma

Due to..... Asthma

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Chester T. H. Simpson

M. D. or other

Address..... Jan 28 1947 Date signed 1-28-47

RECEIVED FEBRUARY 19 THREE QUARTER STATE CALIFORNIA
FEDERAL BUREAU OF INVESTIGATION

RECEIVED

FEB 1 1947

BUREAU F.B.I.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00656

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 2001

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

24 years

Hospital, institution, or street address where death occurred:.....

An home

How long in hospital or institution?.....

3. (a) FULL NAME

Sadie Louis Goodman

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F

Colored

Married

6.(b) Name of husband or wife.....

Wm. Goodman

7. Birth date of
deceased (mo. day, yr.)

Feb 26

6.(c) If alive, give age.....

57

years

8. AGE:

Years

Months

Days

If less than one day

110

1

19

hrs.

min.

9. Birthplace.....

W. Phila. Pa.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

Edwards Bros

MOTHER FATHER

12. Name.....

Edwards Bros

13. Birthplace

Md

14. Maiden name.....

Annie Tiller

15. Birthplace

Md

16. Informant.....

Wm. Goodman

Address

Wilmington Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 11 1947
(month) (day) (year)

Cemetery or crematory

Wilmington Cemetary

Location

Wilmington Md.

18. Funeral director.....

Edward Fellows

Address

Wilmington Md.

Jan. 11 1947
(Date rec'd by registrar)Edward Fellows
Deputy Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Kent

City or town.....

Wilmington

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 7

1947

at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 45

19

to Jan. 7

1947

and that I last saw him alive on Jan. 7

1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

6 days

Due to Hemorrhage

1947

Due to Anemia, Sclerosis & Hypertension

1947

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Munro Vass

M. D. or other

Address.....

Wilmington Md

Date signed

Jan. 8 47

RECEIVED

JAN 18 1947

BUREAU OF INVESTIGATION

2-25

2-2000 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

00657

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: Kent
County: Chestertown

City or town: Chestertown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 10 hours

3. (a) FULL NAME

Herbert Mellor

4. Sex: Male 5. Color of race: White 6. (a) Single, married, widowed, or divorced: Married

8. (b) Name of husband or wife: Eliza Lock Mellor

7. Birth date of deceased (mo., day, yr.): July 20 / 896 6. (c) If alive, give age: years

8. AGE: 50 Years 0 Months 20 Days If less than one day: hrs. min.

9. Birthplace: Philadelphia Pa (Town, county, and state)

10. Usual occupation: Brewer to Officers

11. Industry or business: Shipping

FATHER: 12. Name: Jesse Mellor

MOTHER: 13. Birthplace: Philadelphia

14. Maiden name: not known

15. Birthplace: not known

16. Informant: Reed Kent & Queen Anne

Address: Chestertown MD 21630

17. (Burial, cremation, or removal, which?) Burial Date thereof: Jan 11 1947 (month) (day) (year)

Cemetery or crematory: Still Pond Md

Location: Still Pond Md

18. Funeral director: SR Fellows

Address: Still Pond Md

19. Date rec'd by registrar: Jan. 10 1947 Registrar: Clara S. Barnes

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants, give residence of mother)

State: Maryland County: Kent

City or town: Chestertown (If outside city or town limits, write RURAL and give nearest town)

Street No.: Ward was I (If rural, give location)

2.(a) If veteran, name war: World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9 1947 at 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from no relatives and that I last saw him alive on Jan 8 as completely conscious and well.

Immediate cause of death: Heart attack Kent DURATION

Due to: 30000 persons 10 hrs

Other conditions: shortness of breath weak back

Other conditions: partial Paralysis partial palsies 3 Jr

Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Pneumonia Date of: Jan 8/47

Accident, suicide, or homicide: Pneumonia Date of: Jan 8/47

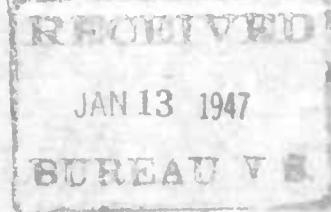
Where did injury occur? Bethelton Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Beaten Injured at work? Yes Date injured: Jan 8/47

Injury: Knock down & hit head hit G

23. SIGNATURE: R. Weller M. D. or other: West from Md Date signed: Jan 9/47



~~The exact age
is especially important.~~
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

06658

Reg. Dist. No. 210210

1. PLACE OF DEATH: Kent
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 40 days
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 Kent and Queen Anne's
 How long in hospital or institution? 40 days

3. (a) FULL NAME
 Ella Sparks Pennington

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6. (b) Name of husband or wife..... William D. Pennington

7. Birth date of deceased (mo., day, yr.) October 24, 1864

8. AGE:	Years	Months	Days	If less than one day
	82	3	5	hrs. min.

9. Birthplace..... Near Chestertown, Kent, Md.
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Solomon Sparks

FATHER 12. Name..... Frances Baker

MOTHER 14. Maiden name..... Nr. Chestertown, Kent, Md.

15. Birthplace.....

16. Informant..... Hospital Records

Address.....

17. Burial..... Jan 31 '47
 (Burial, cremation, or removal. Which?) Cemetery or crematory..... Still Pond

Location..... Still Pond, Md.

18. Funeral director..... B.R. Fellows per V.N.T.

Address..... Still Pond, Md.

19. Jan 30, 1947
 (Date rec'd by registrar) Clue S. Barnes
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland Kent
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 29 1947 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 30 1946 to January 29 1947 and that I last saw her alive on January 29 1947

Immediate cause of death..... Myocardial failure

Due to..... Sepsis

Due to..... Accidental fall. Cerebral

Other conditions..... Fracture left hip.

40 days

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident..... Date of December 19, 1946

Where did injury occur?..... Still Pond, Kent, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury..... Accidental fall. Injured at work?

23. SIGNATURE..... Al C. Dick, M.D.

M. D. or other.....

Address..... Chestertown, Md. Date signed. 1-29-47

RECEIVED

FEB 1 1947

BUREAU F.B.I.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00659

CERTIFICATE OF DEATH

Reg. Dist. No. 90210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
 County..... Kent
 City or town..... Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... all life
 Hospital, Institution, or street address where death occurred..... Queen St.
 How long in hospital or institution?.....

3. (a) FULL NAME

Herbert C. Perkins

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Married

6. (b) Name of husband or wife..... Clara V. Perkins

7. Birth date of deceased (mo., day, yr.) September 10 1875

 8. AGE: Years Months Days It less than one day
 71 4 7 hrs. min.

 9. Birthplace..... Chestertown Maryland
 (Town, county, and state)

10. Usual occupation..... attorney

11. Industry or business..... law

12. Name..... James Alfred Perkins

13. Birthplace..... Chestertown Kent Co. Md.

14. Maiden name..... Mary Chi Blackiston

15. Birthplace..... Kent Co. Maryland

16. Informant..... Mrs. Clara V. Perkins

Address..... Chestertown Maryland

 17. Burial (Burial, cremation, or removal, Which?) Date thereof..... 11/20/47
 (month) (day) (year)

Cemetery or crematory..... Chestertown

Location..... Chestertown Maryland

18. Funeral director..... Marvin W. Williams

Address..... Chestertown Maryland

19. Date rec'd by registrar..... Jan. 20 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State..... Maryland County..... Kent
 City or town..... Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Queen St.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... January 17 1947 at 10:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-15 1947 to 1-17 1947

and that I last saw h. live alive on 1-17-47

Immediate cause of death.....

Emphysema Thrombosis

Due to..... Emphysema arteriosclerosis -
and years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

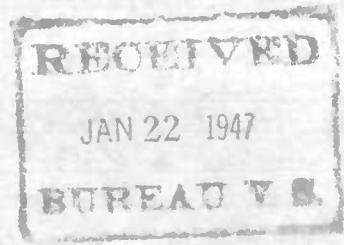
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE..... R. Reed W. Farr M. D. or other

Address..... Chestertown, Md. Date signed 1-18-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

00660

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: Kent
 County
 City or town Chestertown

(If outside city or town limits, write RURAL and give nearest town) 58

How long in above place of death? 58

Hospital, Institution, or street address where death occurred: Kent and Queen Arms

How long in hospital or institution? 6 days

3. (a) FULL NAME

Donald Ferguson Starn

4. Sex	5. Color or race	6. (c) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

Leonore Wilmer Starn

living

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 18, 1888

8. AGE: Years Months Days If less than one day

58 0 20 hrs. min.

9. Birthplace Chestertown, Kent, Maryland
 (Town, county, and state)

10. Usual occupation Pharmacist

11. Industry or business Dryg

12. Name Calvin Starn

13. Birthplace Maryland

14. Maiden name Annie Roberts

15. Birthplace Kent, Chesapeake

16. Informant Hospital Records

Address Chestertown, Md.

17. Burial Burial Date thereof Jan. 14, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Chester Cem.

Location Chestertown, Md.

18. Funeral director J. Willis Wells

Address Chestertown, Md.

19. Date rec'd by registrar Jan. 13, 1947

Registrar Clarinda Barnes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent

City or town Chestertown (If outside city or town limits, write RURAL and give nearest town)

Street No. 60 (If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (b) Social Security Number

No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1947 st 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 6, 1947 to January 12, 1947

and that I last saw him alive on January 12, 1947

Immediate cause of death

Coronary occlusion

Atrial fibrillation

Due to Coronary insufficiency

7

Due to Hypertension

3 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. C. Dick, M.D. M. D. or other

Address Chestertown, Md. Date signed 1-12-47

RECEIVED

JAN 15 1947

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195d

00661

Reg. Dist. No. 202

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Kent

City or town..... Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kent & Queen Anne Co. Hospital

How long in hospital or institution?

3. (a) FULL NAME

Walter Albert Taylor

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife..... none

7. Birth date of deceased (mo., day, yr.)

Dec. 30, 1946

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

B. Birthplace..... Kent Co. Maryland

(Town, county, and state)

10. Usual occupation..... none

11. Industry or business

12. Name..... George Otto Taylor

13. Birthplace..... Kent Co. Maryland

14. Maiden name..... Florence K. Yackle

15. Birthplace..... Phila. Penna

16. Informant..... Mrs. George Otto Taylor

Address..... Chestertown, Md. R.F.D.

17. Burial.....

Date thereof..... Jan. 15, 1947
(month) (day) (year)

Cemetery or crematory..... Chestertown Cem.

Location..... Chestertown, Md.,

18. Funeral director..... J. Willis Wells

Address..... Chestertown, Md.

19. Jan. 15 1947
(Date rec'd by registrar)Clara S Barnes
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne

City or town..... R.F.D. * Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 14 1947 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 12 1947 to Jan 14 1947

and that I last saw h. m. alive on Jan 14 1947

Immediate cause of death.....

Anoxemia

Due to.....

Ingestion of
iron for material

Other conditions.....

Hemo. trachea (smash)

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur? Chestertown, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

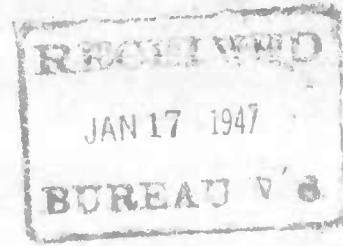
Means of injury.....

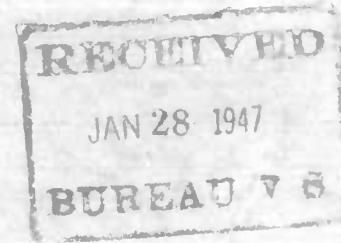
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Chestertown, Md. Date signed..... Jan 14/47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00663

CERTIFICATE OF DEATH

1310
Reg. Dist. No. 203

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

Herbert Alpheus Uriel

4. Sex

m.

5. Color or race

Wh.

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife.....

Mrs Ethel Uriel

6.(c) If alive, give age..... 61 years

7. Birth date of

deceased (mo. day, yr.)

July 6 1883

8. AGE:

Years

63

Months

6

Days

-

If less than one day

hrs.

min.

9. Birthplace.....

Rock Hall, Md

(Town, county, and state)

10. Usual occupation.....

Bank cashier

11. Industry or business

Peoples Bank of Chestertown

Henry 7 miles

12. Name.....

MOTHER

Rock Hall, Md

13. Birthplace.....

Carrie Satterfield

FATHER

14. Maiden name.....

Rock Hall, Md

15. Birthplace.....

Carrie Satterfield

16. Informant.....

Rock Hall, Md

Address

17. Burial

Burial

(Burial, cremation, or removal, Which?)

Date thereof Jan 8-1947

(month)

(day)

(year)

Cemetery or

removal

Wesley Chapel

Location

Rock Hall, Md

18. Funeral director.....

Edgar L. Lane

Address

Lohinch Hill, Md

19. If

7

Date rec'd by registrar

19. 47

S. Elwood Bryan

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... January 6 1947 at 6:42 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12 1946 to Jan 6 1947

and that I last saw h. i. alive on Jan 5 1947

Immediate cause of death.....

Cerebral

thrombophlebitis

Due to..... Hypertension

Due to..... Arteriosclerosis

Arterio 2ndo - myocar. & elitis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Albert A. Burgard

M. D. or other

Address..... Rock Hall, Md Date signed 1/6/47



1-35

PLEASE WRITE ALONE, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

06664

Reg. Diat. No. 202

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Kent
City or town..... Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, Institution, or street address where death occurred:

208 Calvert St.

How long in hospital or institution?.....

3. (a) FULL NAME

Josephine Wells

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	colored	married

6. (b) Name of husband or wife..... John Wells
living.....

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1879

8. AGE: Years 67 Months 4 Days 3 If less than one day hrs. min.

9. Birthplace..... Kent Co., Maryland
(Town, county, and state)

10. Usual occupation..... housewife

11. Industry or business

MOTHER FATHER
12. Name..... Joseph Mitchell
13. Birthplace..... Maryland

MOTHER
14. Maiden name..... Charles-Anna Mitchell
15. Birthplace..... Maryland

16. Informant..... John Wells (husband)
Address..... Calvert St. Chestertown, Md.

17. Burial..... Date thereof Jan. 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Quaker Neck (col.) Cem.
Location..... Near - Chestertown, Md.

18. Funeral director..... J. Willis Wells
Address..... Chestertown, Md.

19. Date rec'd by registrar..... Jan. 14, 1947
Registrar..... Clara S. Barnes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... Maryland County..... Kent

City or town..... Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war..... no

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 12, 1947 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 1, 1947, to Jan. 12, 1947, and that I last saw her alive on Jan. 11, 1947.

Immediate cause of death..... Cancer

Due to..... Atherosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... H. Grinpers

M. D. or other

Address..... Chestertown Date signed..... Jan. 13, 1947

RECEIVED

JAN 16 1947

BUREAU

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00665
2030

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH:

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

all day

Hospital, institution, or street address where death occurred:

Chapman

How long in hospital or institution?.....

3. (a) FULL NAME

Robert Wright

4. Sex

M

5. Color or race

C

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....

(late) Jasmin Wright

7. Birth date of deceased (mo., day, yr.)

Feb. 26 1894

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

72

10

27

hrs.

min.

9. Birthplace.....

Kent Co Maryland

(Town, county, and state)

10. Usual occupation.....

Waterman

or shrimper

11. Industry or business.....

or shrimper

12. Name.....

Joseph Wright

13. Birthplace.....

Kent Co. Maryland

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Mr. Clemente Wright

Address

Rock Hall, Maryland

17. Burial.....

Burial

Date thereof.....

1/25/47

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Sandy Bottom

Cemetery or crematory.....

Location.....

Hear Fairle, Kent Co. Maryland

18. Funeral director.....

Maine V. Williams

Address.....

Chesapeake, Maryland

19. Date rec'd by registrar.....

1/25/47

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Kent

City or town.....

Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Chapman

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

January 22 1947 at 10:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1946 to January 22 1947

and that I last saw him alive on January 22 1947

Immediate cause of death.....

chronic 20-30 year arteriosclerosis

hypertension

Due to.....

arteriosclerosis

Due to.....

gangrene of both feet

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

Albert D. Burgess

M. D. or brother

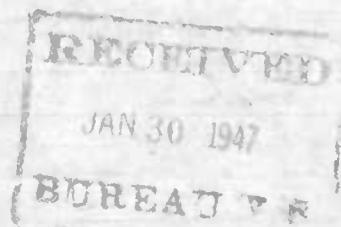
Address.....

Rock Hall, Md.

Date signed

RECEIVED BY ESTIMATED DATE OF RECEIPT

RECEIVED BY MAIL



1-35